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Health Care News

©2003 The Heartland Institute | The Monthly Newspaper for Health Care Reform | Vol. 3 No. 3 ~ March 2003

Jury Awards Forcing Doctors off the Job

A physician holds a protest sign at a rally at the New Jersey Capitol Complex on February 4, 2003 in Trenton, New Jersey. About 3,000 health care workers attended the protest calling for action against skyrocketing malpractice insurance. Many physicians are leaving the state to practice elsewhere due to exorbitant awards won by lawyers, thus increasing insurance premiums.

JAMES M. TAYLOR AND CONRAD F. MEIER

Doctors in West Virginia and Nevada opened the new year by following through on threats to walk off the job in response to prohibitively high malpractice insurance premiums. In Pennsylvania, last-minute state action persuaded doctors to stay in their offices ... at least for now.

In Georgia, nearly one in five doctors is refusing to perform high-risk medical procedures, including delivering babies. A survey of 2,200 Georgia doctors found 18 percent expect to stop performing such procedures in order to limit their liability. Nearly 11 percent have stopped or will stop providing emergency room services.

According to a new study by the Georgia Board for Physician Workforce, hundreds more are leaving the state or retiring outright because of high medical malpractice insur-

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Long-term Care Crisis Builds

STEPHEN A. MOSES

State governments face their worst fiscal crises in 50 years. The federal budget flipped from a triple-digit surplus to a triple-digit deficit. Medicaid, which accounts for 20 percent of state budgets and 7 percent of the federal budget, is a large part of the problem.

Long-term care (LTC) expenditures, consisting of payments for home care and nursing home care, consume a quarter to a half of most states' Medicaid budgets, and the federal government pays 57 percent of all Medicaid costs. Nevertheless, punishingly low Medicaid and Medicare long-term care reimbursements have driven thousands of nursing homes and home health agencies into bankruptcy.

Is this just the price of providing a long-term care safety net for the poor? Or have state and federal policies crowded out private financing alternatives and exploded long-term care costs unnecessarily? The answer may surprise you.

Medicaid Is Welfare

Medicaid is a means-tested public assistance program. It is welfare. People who need acute, emergency, or preventive health care must be dirt poor to qualify for Medicaid.

For anyone who needs nursing home care, however, the eligibility rules are very different and highly generous. Despite the conventional wisdom that people must be poor to qualify for Medicaid nursing home benefits, income only dis-

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Bush Sends Mixed Signals

JOSEPH L. BAST

In his State of the Union Address on January 28, President George W. Bush mentioned a prescription drug benefit and the need to get affordable drugs to AIDS patients in other countries. Both are important matters, and the President addressed them with his usual candor and common sense.

However, Bush implied that a prescription drug benefit has to be enormously expensive (though less expensive than Democrats want). And his comments on the AIDS problem seemed to assume the price system isn't work-

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The Politics of Medicare Reform

DAVID GRATZER

Emboldened by a desire to make the program sustainable, Republicans were preparing what they claimed would be the most sweeping changes to Medicare in a generation. In Washington, there was a buzz. The *New York Times* reported in a front-page story that Republicans planned to make "vast changes in Medicare, offering new health insurance options to the elderly, broadening coverage of preventive services, and creating strong new financial incentives for managed care companies ..."

Rep. Pete Stark (D-California) struck back: "[They] seek to promote managed care and to encourage the great mass of beneficiaries to join managed care plans, while letting the richest doctors and patients in our society avoid the inconveniences of managed care." Hoping to sound a note of compromise, Republican spokesman Ari Fleischer promised: "We'll work cooperatively and constructively"

Deja Vu?

Does this sound like recent news? *Actually, all this took place in the summer of 1997.* And if Republicans aren't prepared to be bold by offering a sweeping vision for Medicare, they will fail again.

It was five years ago that congressional Republicans, led by a handful of senators including Bill Frist, hoped to introduce reforms as part of the balanced budget agreement that would make Medicare "sustainable." Ari Fleischer, incidentally, was spokesman for the Ways and Means Committee.

The reforms of 1997, like the ill-fated efforts of 1995, proved disastrous. Republicans proposed adding private options but settled for the unworkable Medicare + Choice; they fought for fiscal sanity and ended up agreeing to price controls. Herein lies the big worry for Republicans today: Will they fall short again?

Republican health proposals have, as of late, smacked of a "me-too" strategy. Democrats support a heavy-handed Patients' Bill of Rights, children's health coverage, and mental health parity; Republicans espouse modest versions of the same. The idea of a prescription drug benefit originated with the Democrats.

Polling well as an issue, Republicans me-too'ed—with a twist. Last year, President Bush made clear a benefit could be added only if a Medicare overhaul was part of the package. Republicans thus offered the carrot of program expansion with the stick of restructuring.

And thus, a certain sense of deja vu: Republicans promising again to "modernize" Medicare. Of course, they have crucial advantages over their last attempt: first and foremost, a sympathetic President.

"Rather than funding services, Medicare ought to fund people, allowing them to choose the services they want covered and the types of co-payment."

But Republicans failed not so much because of their inability to persuade then-President Clinton of the wisdom of reforms so much as for their inability to make a case to the American people. In 1995 and 1997, Republicans spent much political capital trying to sell Americans on a combination of premium hikes and program cuts; in other words, more for less. Today, Republicans should offer a sweeping vision.

Achilles Heel

Medicare is structurally flawed; no company could sell such insurance in any of the 50 states. Medicare remains ossified in time, covering the same types of services as it did when it was created. But if Medicare hasn't changed much since the days of LBJ, medicine has. The result is a bizarre patchwork of coverage: The elderly are entitled to a cane or a walker, but not both—and something as basic as pharmaceuticals is not covered at all. Medicare pays too many small bills (what the elderly could afford themselves) while leaving them exposed to heavy expenses like drug costs.

How to reform Medicare? Rather than funding services, Medicare ought to fund people, allowing them to choose the services they want covered and the types of co-payment. Medicare, in other words, should switch from defined benefits to defined contributions, giving elderly Americans more freedom with their health insurance.

Flexible plans would offer a way to add prescription drug coverage. The alternative—what so many House Democrats support—would be to simply tack on drugs to the status quo. It would be a $350 billion addition to a collapsing house, further adding to the red tape, inflexibility, and general confusion.

Sensing a repeat of the mid-1990s debacles, some Democrats are licking their lips.

In January, Stark's chief of staff told reporters: "If the price of a prescription drug benefit is the end of Medicare as we know it, that's not a price worth paying." A good response would be pointing out that federal employees can choose among competing health plans. Why can't America's seniors?

Senior Power

The answer is the gray lobby. With its well-oiled political machine, the AARP—and other such organizations—vigorously opposes any talk of market reforms. Should Republicans attempt to really reform Medicare, the gray lobby will offer an aggressive public campaign aimed at humiliating and embarrassing congressional leaders.

Americans wouldn't have seen anything like it since Republicans took on the welfare lobby—and implemented the most sweeping changes in a federal program in a generation.

Dr. David Gratzer is a Toronto physician and Manhattan Institute senior fellow for health policy. Gratzer's first book, Code Blue, *won the prestigious Donner prize, the highest honor for a Canadian public policy book.*

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JURY continued from page 1

ance rates. Four percent of the state's doctors have decided to leave the state or retire from medicine.

The 2002 malpractice insurance rates reported by the Georgia doctors surveyed ranged from just under $8,000 a year for psychiatry to more than $60,000 for neurosurgery; obstetricians reported paying nearly $50,000. The surveyed doctors reported premium increases of anywhere from 11 percent to 30 percent in the last year. About 13 percent of doctors reported they had difficulty finding malpractice insurance coverage.

Doctors Walk in West Virginia

In West Virginia, neurosurgeons now pay an average of $134,000 every year in malpractice insurance premiums. Doctors assert their January 1 walkout was necessitated by their inability to continue paying skyrocketing malpractice premiums.

"This is not a strike," said Dr. Gregory Saracco, a general surgeon at Wheeling Hospital. "I'm not protesting anything. I'm taking time to look at other options. But if I don't get some help to offset my premium costs, I can't operate in this state."

Although many doctors were still practicing despite the walkout, the threat remains that more of them will be driven out of business if the state does not act soon.

"I'm afraid this is just the first bit," said Parkersburg family practitioner David Avery. "If the governor and the legislature don't act, this will be spread quickly across the state, and it will be all physicians, not just surgeons."

Nevada Legislation Not Enough

In Nevada, many Las Vegas physicians stayed home from work to draw attention to their escalating insurance premiums. The Nevada legislature had passed a tort reform package that took effect October 1. The legislation caps pain-and-suffering damages at $350,000, but allows exceptions for gross malpractice and cases where a judge finds "exceptional circumstances." Physicians have asserted the legislation has not gone far enough, and that malpractice insurance premiums have failed to moderate.

"An unprecedented number of doctors are leaving Las Vegas," noted Dr. Tom Purdon, former president of the American College of Obstetricians and Gynecologists. "Southern Nevada has become the worst place in the country for women trying to find prenatal care."

Pennsylvania Promises Reform

Democratic Governor Ed Rendell barely averted a physicians' walkout by promising to seek reform ... but the centerpiece of his short-term fix is already under attack. Rendell wants to take $220 million from the surplus funds of big health insurance companies and use that money to curb some of the liability premium inflation.

While doctors say they like the idea, major health insurance companies are gearing up to fight the plan. They don't even write medical malpractice insurance, they say, and thus should not be forced to foot the bill.

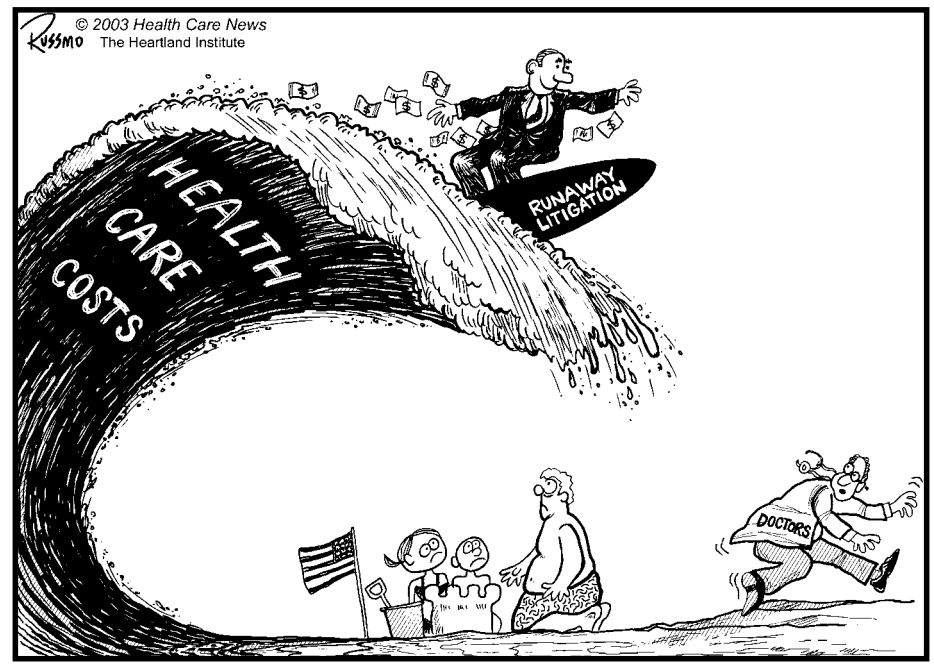
According to James Richmond, a member of the governor's emergency task force on health care and senior vice president of the Pennsylvania Hospital Association, "when you rob Peter to pay Paul, everyone is in favor of it except Peter."

Florida out of Time

In Florida, Republican Governor Jeb Bush promises reform is at the top of his agenda. But some doctors can't wait for reform to make its way through the legislature.

"[B]etween 1999 and 2000, the latest year for which statistics are available, the median malpractice jury award rose 43 percent. The average award is now a whopping $3.5 million."
Roll Call

Jill Mahassey and her daughter Katie attend a news conference on health care issues. Mahassey had difficulty finding pre- and post-natal health care because high malpractice insurance rates are causing doctors to leave medicine.



In Manatee County, comprised of Tampa suburbs, 40 percent of the local kidney specialists have been unable to renew their liability coverage for 2003. "Interruptions could extend way beyond the physician's immediate practice," warned Thomas Braxton, chief of staff at Manatee Memorial Hospital. "If none of the kidney specialists had found coverage, the crisis would have shut down open heart surgery centers at local hospitals, because Medicare requires a kidney specialist be on call during those procedures."

Other areas of the state have similar problems, as doctors close up shop or move elsewhere in the wake of huge jury verdicts and hefty premium increases. Four years ago, more than 40 companies offered medical malpractice coverage to Florida physicians. Now only a handful remain, and premiums have risen by as much as 400 percent in just the past several months.

"I can tell you that based on my experience, if this starts to affect any large number of physicians, [a walkout] would rapidly be contemplated," warned Braxton.

Tidal Wave of Awards

In the wake of increasingly hefty jury awards, insurance companies offering malpractice coverage have either been forced out of business or required to raise premiums dramatically. Jury Verdict Research, a database of more than 202,000 verdicts and settlements, reports that between 1999 and 2000, the latest year for which statistics are available, the median malpractice jury award rose 43 percent. The average award is now a whopping $3.5 million.

Jury Verdict Research serves both plaintiffs' and defense attorneys, with an equal emphasis on plaintiff and defense verdicts and settlements, and with no intentional bias toward extreme awards or specific geographic regions.

The growing number of extreme awards and settlements has meant dramatic increases in malpractice insurance premiums. Between July 2001 and July 2002, average insurance rates across the country increased 29.1 percent for general surgeons, 17.6 percent for internal medicine specialists, and 12.5 percent for obstetricians/gynecologists. Some doctors now pay $200,000 a year or more for their malpractice coverage.

Malpractice insurance rate increases vary significantly from state to state, in large part reflecting the strength (or weakness) of each state's protections against eye-popping settlements.

According to the American Medical Association (AMA), rising premiums have created a "crisis" in 12 states: California, Florida, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. Another six sates are identified by the AMA as being on the verge of a crisis.

Some of the crisis states, including Mississippi, Nevada, Ohio, and Pennsylvania, have recently attempted to address their emergencies through various types of reform legislation. Most of those efforts appear to offer at best a partial solution.

Bush Proposes Reform ...

Responding to the growing crisis in the states, President George W. Bush on January 16 proposed national malpractice tort reform before a cheering crowd in Scranton, Pennsylvania.

"You can pretty well blackmail a doctor into settlement if you continue to throw lawsuit after lawsuit," said Bush. "And the system looks like a giant lottery."

He added, "It is a national problem that needs a national solution."

Under the Bush proposal, non-economic damages such as emotional distress and pain and suffering would be capped at $250,000. The proposal is similar to legislation Bush supported last July—a measure defeated in the U.S. Senate by a 57-42 vote. The President is hoping Republican gains in the mid-term elections will give reform legislation a better chance in the current Congress.

... But Democrats Oppose It

Four Democratic senators wrote a letter in response to the Bush proposal, arguing it would deny justice to seriously injured plaintiffs and do little or nothing to reduce malpractice insurance

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Virginia Regulators Seize Malpractice Insurer

Michael Prince

Virginia insurance regulators placed troubled medical malpractice insurer Reciprocal of America into receivership on January 29.

After reviewing the company's finances, the state's Bureau of Insurance found the insurer "to be in a hazardous financial condition" and ordered it to stop writing new policies or renewing existing ones. Reciprocal of America, based in Glen Allen, Virginia, is a unit of Richmond-based The Reciprocal Group.

The company, which operates primarily in Alabama, Kentucky, Mississippi, Tennessee, and Virginia, in December asked its member physicians and hospitals for help in raising $100 million by January 31. A request earlier in 2002 seeking $60 million raised only $53 million, Reciprocal stated in its December letter to subscribers. In 2001, Reciprocal wrote direct premiums of $121 million.

A.M. Best Co. downgraded the company's financial strength rating to B- from A- on March 27, 2002, and further downgraded the rating to C- then E—under supervision—upon the state's takeover.

A major blow for Reciprocal, which faced mounting claims, was the decision by its Bermuda-based reinsurer, First Virginia Reinsurance Ltd., not to honor its reinsurance obligations, according to Virginia regulators. First Virginia's decision cost the insurer $29 million, Reciprocal's records show. In a December 26, 2002, letter to its subscribers, Reciprocal called this "our biggest financial issue."

With the company no longer writing business, current policyholders will need to find another insurer, said a spokesman for the Virginia Corporation Commission. The company referred all questions to state regulators.

Michael Prince writes for BusinessInsurance.com, where this story appeared on January 30. *His email address is* mprince@crain.com.

premiums. The statement echoed arguments made by trial lawyer groups, who contend malpractice premiums mirror stock market gains and losses rather than the size of jury verdicts.

"The real beneficiaries of these proposals would be the liability insurance companies, not patients and not doctors," said the letter from Senators Dick Durbin of Illinois, John Edwards of North Carolina, Edward Kennedy of Massachusetts, and Patrick Leahy of Vermont.

"The truth is the insurance industry has done poorly in the market and is simply passing those costs on to doctors and patients," said Edwards, a millionaire trial lawyer before being elected to the Senate, in a separate statement.

"[B]etween 1999 and 2000, the latest year for which statistics are available, the median malpractice jury award rose 43 percent. The average award is now a whopping $3.5 million."

On the other side of that argument, practicing physicians and the American Medical Association were quick to confirm the link between ever-increasing jury verdicts and their rising malpractice premiums. AMA President Donald Palmisano reported runaway juries are the primary cause of recent increases in malpractice premiums.

"Unfortunately, our medical-liability litigation system has become an increasingly irrational lottery driven by open-ended, non-economic damage awards," said Palmisano.

Palmisano's assessment was supported by Pat Hirigoyen, a spokesman for the St. Paul Companies, which insured 9 percent of the nation's physicians before it was driven out of the malpractice insurance business a year ago.

"In 2001 alone, we lost $1 billion on this business even though we had been getting rate increases," said Hirigoyen. He further reported the company had lost money for five straight years—long before the current stock market and economic downturn—before finally halting its underwriting of malpractice premiums.

Without congressional action on his reform legislation, said Bush, "Excessive jury awards will continue to drive up insurance costs, will put good doctors out of business or run them out of your community, and will hurt communities like Scranton, Pennsylvania. That's a fact."

Fair Compensation Needed

Writing in the January 27 *Wall Street Journal Opinion*, Philip K. Howard, a lawyer and author of *The Collapse of the Common Good*, suggests "America needs a special medical court or tribunal, just as we have separate courts for patents and other specialized problems. Sensible judgments will be possible only when doctors, hospitals and other providers feel that justice will reliably distinguish between right and wrong, make predictable judgments about fair compensation, and provide the right incentives for overall quality for health care."

Howard further wrote, "A trusted system of justice is the key. Without it, health care will continue to careen downwards, driven by legal fear instead of humane care."

James M. Taylor is an attorney and managing editor of The Heartland Institute publication, Environment & Climate News. *Conrad F. Meier is senior fellow in health care policy and managing editor of* Health Care News.

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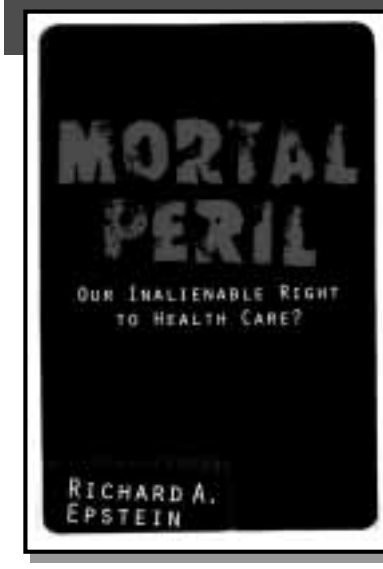

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ing to give AIDS patients access to needed drugs, justifying drug pirating by countries such as India. Neither of these assumptions is correct.

Prescription Drug Benefits

The President made it clear he supports a private and flexible drug benefit, not one that is government-controlled and inflexible, and that the benefit must be part of Medicare reform. This is good. Reforming Medicare will be the biggest battle over health care in our generation. Bush is courageously addressing the need to reform a program that has been failing seniors for years, but was too politically sensitive for other politicians to address.

Medicare has to change to include prescription drug coverage because the role of drugs in medicine has grown since Medicare was created in 1965. A system of insurance that covers surgery but not medication leads to higher spending, more pain and suffering, and more time lost for recovery and rehabilitation. It cheats seniors of the benefits of today's life-saving and life-extending wonder drugs.

Medicare also must move in the direction of markets, property rights, personal responsibility, and choice. This is the direction the whole world is moving. Domestically, we have seen it in deregulation, welfare reform, and privatization. Internationally, we see it in the fall of the Berlin Wall, collapse of the Soviet Union, and spread of free trade and free markets to countries such as China.

Medicare is increasingly an anachronism in the U.S., an island of socialism and government monopoly surrounded by free enterprise, innovation, and consumer choice. That cannot continue.

Bush's comments are encouraging, but there is also a risk. His pilot program for Medicare reform, announced late last year (and reported in the November 2002 issue of *Health Care News*) avoids government controls, open-ended entitlements, and price controls ... but takes the muddy middle of the road in advocating more reliance on HMOs and PPOs to cover seniors. This may not be the right model.

"There is good evidence that actions by India and other developing countries that undermine patent protection have already slowed the development and commercialization of new drugs to treat AIDS."

Managed care helped control spending for several years, but it produced a backlash from patients upset over the loss of control and growth of expensive bureaucracy. Providers, too, have rebelled, and by organizing themselves they have managed to undo much of the early savings.

Better approaches are tax credits for insurance, association health plans, expanded Medical Savings Accounts, and repealing expensive mandates, community rating requirements, and other cost-raising and access-reducing regulations.

By advocating a prescription drug benefit delivered by PPOs and other types of managed care, the President may play into the hands of Senators Hillary Clinton (D-New York) and Edward M. Kennedy (D-Massachusetts), and other advocates of single-payer health care.

They will attack and seek to demonize anything short of open-ended government-guaranteed entitlements. Once prominent advocates of HMOs, they will now attack Bush for "forcing people into HMOs" in order to get prescription drug coverage. They will call for price controls and more subsidies, regardless of what the President offers.

Although Clinton, Kennedy, et al. may want to frame the debate as a replay of the 1993 fight over Hillarycare, Bush should not allow them to do so. Hillarycare is dead because it was a backward-looking reform, out of sync with the national and world movement toward markets, innovation, and consumer choice. It was a big-government solution from an administration that would later admit "the end of the era of big government" has arrived.

Dealing with AIDS

Bush surprised many listeners by devoting part of his State of the Union address to the problem of AIDS in developing countries. He called for spending $15 billion over the next five years and new international efforts to make AIDS drugs less expensive and more available in poor countries.

The President's compassion is commendable, but once again the path he suggested is questionable.

There is good evidence that actions by India and other developing countries that undermine patent protection have already slowed the development and commercialization of new drugs to treat AIDS. Moreover, the cost of drugs is not the principal reason why the impoverished people of Africa lack treatment. More important are the absence of hospitals, care givers, and the rest of the public health infrastructure needed to deliver treatment. Many more lives would be saved if funds were invested in these essential services and facilities, than in buying expensive AIDS medications. It's a tough choice, but it's a choice that must be made in a world of limited resources and overwhelming needs.

The President needs to take a firm stand for patent protection and against pirating, even in the tough case of AIDS drugs.

The President should focus his attention, both in the Medicare arena and AIDS, on allowing people to choose and private companies to innovate and compete.

Solutions usually are to be found in lower taxes, less regulation, and protection of property rights (including patent protection), not in new bureaucracies, new entitlements, or more regulations. So long as the President keeps this in mind, he and his political party will be on the right track on health care issues.

Joseph L. Bast is president of The Heartland Institute.

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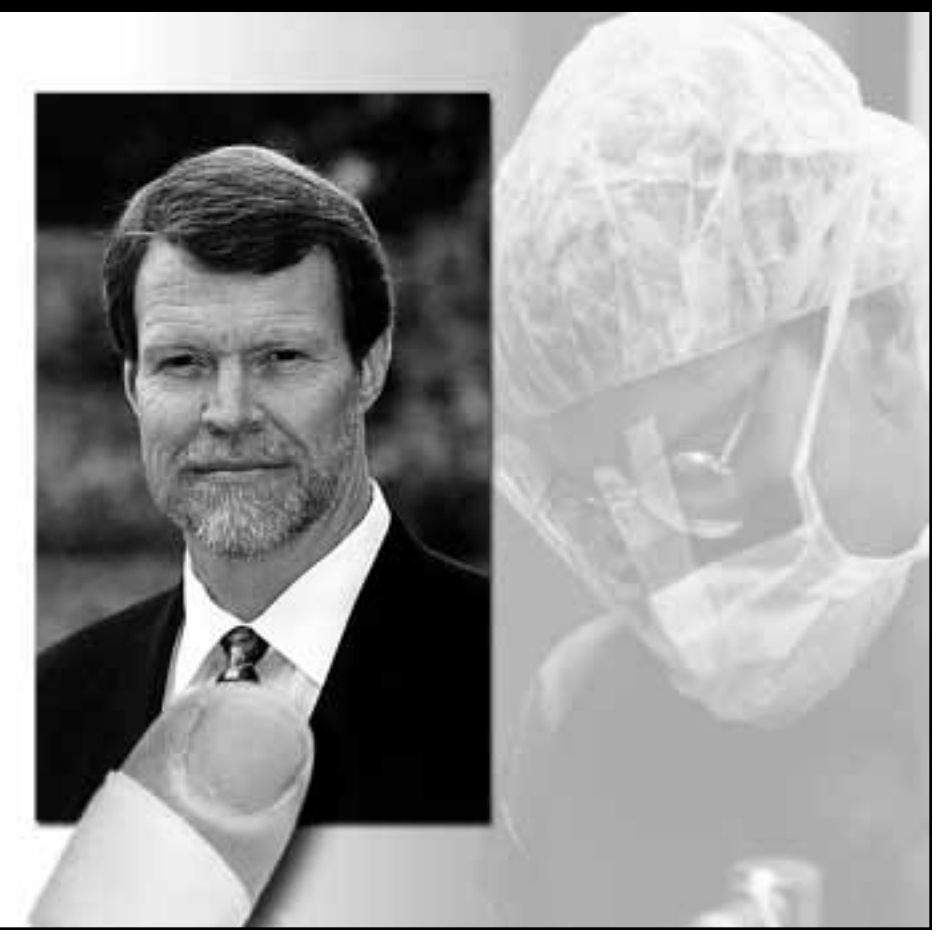

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TAA Contains Health Benefits with State Implications

JANET TRAUTWEIN

Last August, President George W. Bush signed into law the Trade Adjustment Act of 2002 (TAA), helping eligible individuals maintain their health insurance if they lose their jobs due to trade arrangements. Persons covered by the TAA are eligible to receive a refundable tax credit for 65 percent of the premium cost for qualified health insurance plans. Options that qualify for the tax credit are specifically outlined in the legislation and include COBRA, purchasing pools, state continuation plans, and high-risk pools, among others.

Some of the options are automatically available to eligible individuals under TAA: COBRA, coverage under a spouse's employer-sponsored plan, and existing individual health insurance coverage. For other coverage options—high-risk pools, private purchasing pools, state-based continuation coverage, and state employee health insurance programs, for example—legislative or regulatory action by state officials is necessary to expand eligibility to TAA eligibles, even if the option is already in existence in the state.

A person does not have to have been previously insured in order to qualify for the TAA tax credit, but individuals without prior coverage would be subject to the same pre-existing conditions limitations as other participants in the type of coverage option the state selected. If a TAA-eligible individual had been previously insured for three months and had less than a 63-day break in coverage, the option selected must extend coverage on a guaranteed-issue basis and without application of a pre-existing conditions waiting period.

TAA and High-Risk Pools

TAA also provides new funding for high-risk pools, an essential tool for increasing the number of Americans covered by health insurance.

"Persons covered by the [Trade Adjustment Act] are eligible to receive a refundable tax credit for 65 percent of the premium cost for qualified health insurance plans ... [including] COBRA, purchasing pools, state continuation plans, and high-risk pools, among others."

Typically, a high-risk pool is a state-created nonprofit association offering comprehensive health insurance benefits to individuals with pre-existing medical conditions.

High-risk pools play an important role in our health care system. Health care costs and health insurance costs are rising; the new TAA funding will improve stability for existing high-risk pools and encourage the development of pools in states currently lacking this important safety net.

Typically, individuals seek coverage in a high-risk pool for one of three reasons: They have been turned down for coverage in the private individual market due to a chronic illness or condition; they can purchase only limited coverage due to their health; or they have coverage that costs more than what is available from the pool.

TAA authorizes grants of up to $1 million each to states for the creation of a high-risk pool if they don't have one, or if their existing pool is not currently qualified. Many states have been unable to implement high-risk pools due to funding shortfalls, and the ability to obtain initial start-up funds will be extremely helpful.

TAA also provides funding to offset losses experienced by pools. While the TAA funds are not intended to be the sole source of funding for pool losses in excess of premiums, TAA money should help financially stabilize existing pools and make them more affordable. TAA funds may also make it possible for the few pools that are either closed or have waiting lists to make changes necessary to ensure their pools can be re-opened and remain open.

In order to qualify for TAA funding to offset losses, the high-risk pool must cap its premiums at 150 percent of a standard rate; two or more plan options must be made available to plan participants; a mechanism other than federal funding must be established to ensure continual funding past the year-end 2004; and the pool must be open to HIPAA eligibles.

Thirty states have already implemented high-risk pools, which have provided affordable health insurance for thousands of individuals who would otherwise be uninsured. The additional federal funding is expected to encourage other states to implement such pools.

Janet Trautwein is vice president of government affairs for the National Association of Health Underwriters (NAHU). For more information call Kelly Loussedes at 703/276-3835 or email kloussedes@nahu.org.

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108th Congress Has Opportunity to Liberate MSAs

Scripps Howard

Sen. John Kerry (D-Massachusetts) questions a witness during a Senate Small Business and Entrepreneurship Committee hearing on health care, February 5, 2003.

JOE MOSER

How well would Individual Retirement Accounts work if they were available only to employees of businesses with fewer than 50 people? What if Section 529 College Savings Plans could be started only by the self-employed? Suppose Sec. 215 Cafeteria Plans were available only to employees whose last name began with a Q?

In each of these cases, artificially limiting demand for the tax-favored plans means fewer companies are willing to supply them. That means fewer opportunities for consumers.

Current MSA Dynamics

The same market rules apply to medical savings accounts (MSAs), which allow consumers to save pretax dollars in an account for out-of-pocket medical expenses. The account must be combined with a qualified high-deductible health insurance plan for protection against catastrophic medical expenses.

The general theory is that the premium savings realized by purchasing a less expensive, high-deductible insurance plan can be placed in the savings account and used for qualified medical expenses, or rolled over from year to year if the holder doesn't use the funds.

The best part of this arrangement is that the *consumer owns the account*. As the owner of the account, the consumer has an incentive to comparison-shop for medical services based on quality and price. The consumer is in control.

MSAs are also more portable than most health insurance plans. Because the consumer owns the account, the account follows him or her from job to job. The money saved in the account stays there, earning interest.

Account balances can be withdrawn tax-free at any time to pay routine medical expenses up to the plan deductible, co-payments and coinsurance after the deductible, or other qualified medical expenses like dental services and vision care. The account also can be used as an investment vehicle for retirement, since account balances can be withdrawn after age 65 without penalty. Before age 65, funds can be withdrawn from the account, but the consumer pays taxes and a 15 percent early withdrawal penalty if the funds are not used for medical purposes.

MSAs reward consumers who shop wisely for health care and encourage a more efficient allocation of resources in health spending. The consumer with an MSA knows insurance isn't paying all or most of his medical bills, so he doesn't have an incentive to over-spend on health services.

"Congress will decide again this year whether to kill the [MSA demonstration] project, extend it again as a demonstration ... or make the program permanent."

Fixing the Flaws

While MSAs are ideal from an economist's standpoint because they "get the incentives right," they have been less than ideal in practice because of the heavy restrictions placed on them by Congress in the enabling Health Insurance Portability and Accountability Act of 1996.

But 2003 offers a unique opportunity for Congress to correct the flaws in the MSA legislation.

MSAs are a demonstration project originally set to expire in five years. In 2001, the expiration date was extended to December 31, 2003. Congress will decide again this year whether to kill the project, extend it again as a demonstration ... or make the program permanent. It is during this reauthorization process that Congress can correct the problems with MSAs to make them a more viable option.

MSA Expansion Checklist

- Make MSAs permanent
- Eliminate 750,000 enrollment cap
- Expand eligibility to all individuals and employers
- Allow employee and employer contributions
- Permit flexible deductibles

The biggest problem with MSAs is that the population allowed to purchase them is quite limited. Under current law, only the self-employed and small businesses with fewer than 50 employees are allowed to purchase tax-advantaged MSAs. This is a relatively small market segment meant to test the effectiveness of the plans, not to encourage broad consumer participation.

Because MSAs are available to only a small portion of the population, many insurers have been hesitant to offer MSA products. State regulations that effectively prohibit high-deductible health plans by loading health insurance with coverage mandates also effectively prohibit MSAs in some states. Market forces cannot function properly in such an environment.

Due to over-regulation and the resulting relatively small number of companies offering MSAs, even some employers and self-employed persons who would qualify find MSAs are not available to them. And even when an MSA provider is willing to offer a plan, the applicant may be disqualified by the insurer's rules and restrictions. While such rules may not be unique to MSAs, they nevertheless inhibit access to the plans.

More insurers would offer MSAs if the demonstration project were made permanent and all employers and individuals were allowed to purchase MSAs. The 750,000 cap on enrollment placed on MSAs at inception should also be removed. A demand exists for MSAs, if only all of the people who could benefit from them could gain access to them. A recent Zogby poll found 89 percent of those polled wanted the option of purchasing an MSA.

Expanding MSAs to make them available to all employers and individuals would help millions of uninsured citizens. A recent Council for Affordable Health Insurance analysis of IRS data found 73 percent of those who had purchased MSAs to date were previously uninsured.

Easing Other Restrictions

Another step Congress can take to make MSAs function better would be to allow both employers and employees to contribute to the account. Currently one or the other can fund the account, but not both. Allowing both to contribute would encourage funding the account to the greatest extent allowable by law: 65 percent of the deductible for individual account holders and 75 percent for families. Increasing the funding possibilities for the account promotes saving for future medical events.

The savings account element of the MSA program is not the only aspect that is heavily regulated. The insurance plans, too, are subject to legislative restrictions. The MSA law mandates that insurance plans offered in conjunction with MSAs must have deductibles between $1,700 and $2,500 for individual policies and between $3,350 and $5,050 for families.

Requiring such narrow deductible ranges reduces the ability of insurers to offer a variety of MSA plans at different premium costs. By allowing flexible deductibles, Congress could give individuals and families the opportunity to purchase plans better tailored to their needs.

Critics say the current MSA demonstration project has resulted in far fewer participants than anticipated, and that this is a reason to believe MSAs don't work. But MSAs have been regulated to fail.

Once legislators liberate the MSA from its shackles, individuals and employers will find it is a winning concept that encourages wise health care decisions by consumers and reduces health spending. Members of Congress would be remiss in letting this opportunity pass by without action.

Joe Moser is a health policy analyst at the Galen Institute and a regular contributor to Health Care News. *The views expressed are the opinions of the author and do not necessarily reflect the views of the Galen Institute.*

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A Health Care Reform Agenda

PART 2 OF 2

BY JOHN McCLAUGHRY

John McClaughry is president of the Ethan Allen Institute, a nonprofit research and education organization based in Vermont. This Agenda was produced with financial support and input from the members of State Policy Network, a national support organization for free-market think tanks.

Reprinted below are the group's recommendations for changes to be made at the *state* level to improve health care in the United States. In the first installment of this two-part series, which appeared in the February 2003 issue, we presented the group's recommendations for *federal*-level reforms.

Desirable State-Level Initiatives

1. States should make sure consumers have ready access to health education and consumer information.

A patient power approach works only when consumers have access to sufficient information to make intelligent choices. State health education programs (including high school curricula) should emphasize personal responsibility for important lifestyle choices.

They should also help consumers learn about various treatment and insurance options, and the qualifications, performance, and cost records of medical care providers. In recent years much useful information has become available through both public and private Web sites and through Internet-based patient groups (an outstanding example is Coloradohealth.com).

2. States should roll back costly health insurance mandates.

Currently the 50 states enforce more than 1,500 mandates on insurance policies, covering such matters as pregnancy, mental healthy parity, substance abuse, and acupuncture. Consumers ought to be allowed to buy low-cost basic policies, and add riders for additional coverage, just as they do with auto insurance.

States should enact the Mandated Benefits Review Act proposed by the American Legislative Exchange Council in 1998. It would create an independent committee charged with reviewing the cost-effectiveness, medical efficacy, and social impact of each benefit mandate. All existing mandates would expire on a date certain unless reauthorized by the legislature. All proposed future mandates would require a financial impact study before legislative enactment.

3. States should allow the sale of low-cost basic coverage insurance policies that do not include cost-inflating mandates.

Whatever the result of mandated benefit rollback, low-cost mandate-free policies should at least be available to lower-income workers and families who lack employer-sponsored insurance, to maximize the likelihood that they will be covered for catastrophic medical events.

4. States that have adopted community rating and guaranteed issue should repeal those laws.

Strict community rating requires insurers to charge the same premium rate to all insureds regardless of their age, gender, medical history, and other factors. (Modified community rating typically allows a rating band of +/- 10-20 percent.)

Community rating is particularly perverse for shifting the costs of insurance from older, more affluent, but less healthy families to younger, healthier families trying to get started in life while bearing the burdens of college loan repayment, home mortgage payments, and entry-level incomes.

Every other form of insurance (auto, property, life) sets premiums that relate to the insured's risk of incurring a loss. By prohibiting health insurers from varying premiums based on age, gender, medical history, and other factors, community rating makes true insurance impossible. The result is invariably the destruction of the insurance market and a reduction in coverage as young, healthy people abandon policies they can no longer afford.

Guaranteed issue requires insurers to accept every applicant at any time regardless of his or her health history. This encourages adverse selection, as people who expect to remain healthy (usually young people) choose to stay out of the insurance pool altogether, sign up for insurance coverage when they foresee the imminent need for coverage, and drop the coverage when they believe they no longer need it.

While both of these mandates lead to demonstrably undesirable results, guaranteed renewability is a mandate that ought to be continued. It requires insurers to continue coverage for any insured so long as premiums are paid; coverage cannot be terminated as a result of high medical costs. Typically the premium for a policy is related to the claims experience of the group of which the insured is a member.

5. States should allow insurers to offer healthy lifestyle discounts.

When states have implemented strict community rating, premium discounts for non-smoking, responsible drinking, or other healthy lifestyle choices are not allowed (because it would shift costs from people with healthy lifestyles to people with unhealthy lifestyles).

Encouraging personal responsibility is a key to sound health care policy. All states ought to allow insurers to offer such discounts for responsible behavior, as they do for auto insurance (driver training, good driving records, air bag use, etc.).

6. States with income taxes should allow taxpayers and third parties to deduct contributions to MSAs.

States can encourage the spread of Medical Savings Accounts by making contributions to MSAs tax deductible. Alternatively, states could match a sliding scale federal tax credit for the purchase of health insurance.

7. States should create Medicaid Health Accounts and insurance vouchers for their acute care Medicaid case load (not including permanent chronic care patients).

This would put Medicaid patients into a normal insurance market and give them the means to buy suitable policies (at least basic coverage). Medicaid-eligible families would be allowed to devote their MHA balances in excess of expected needs to a personal health-related benefit not otherwise covered by traditional Medicaid. Since the MHA is funded by appropriated funds and not by contributions from taxable entities, the federal MSA rules would not apply.

States would also need to supply considerable health information and education to enable MHA families to make wise choices, along the lines of the Florida Cash and Counseling program. An MHA debit card, similar to those increasingly used for TANF (welfare) payments, would be a practical way to manage the accounts.

8. States should create high risk pools.

High-risk pools serve persons with chronic high cost medical conditions, who have been rejected by insurers as uninsurable, or who have been quoted premiums that are far beyond their capacity to pay. Such pools, now in operation in some 28 states, typically charge insureds 150 percent of the normal premium for their classification. The pool's expenses above premiums collected should preferably be financed by state appropriations, but some states finance them in part by a tax on insurance premiums.

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9. States should enact medical malpractice reform as an important component of broad-based tort reform.

States should reform medical malpractice law in the same way as recommended for federal action. (See "A Health Care Reform Agenda," *Health Care News*, February 2003.)

Such action would include

- imposing a limit on non-economic and punitive damages and attorneys' fees;
- ending joint and several liability (where every contributory party is at risk for the entire judgment, regardless of his contribution to the injury);
- adopting a high tort standard of "gross and willful negligence" in medical malpractice cases, in place of a lower standard that allows plaintiff victories where the doctor makes a well-informed, rational judgment call that unexpectedly leads to harmful results (especially important for charitable and humanitarian care); and
- assigning punitive damage awards to state high-risk pools, health information program support, or other public program instead of to the plaintiff's attorney.

10. States should make full-cost payment to Medicaid providers.

Many states have succumbed to the temptation to finance expanded government health care by forcing providers (hospitals, doctors, nursing homes, dentists, etc.) to serve Medicaid populations at significant discounts from the actual cost of services. Faced with this mandatory exaction, providers are forced to increase prices to private patients.

This cost shift leads to higher private insurance premiums, more workers dropping coverage due to the higher cost, and more demand for the expanded but underpaying Medicaid programs. In addition, doctors and dentists may decide to stop treating Medicaid patients.

Medicaid underpayment of true costs is an unlegislated tax on health care providers and through them, on their private patients. If governments are going to qualify citizens to receive health care benefits at nominal cost, governments must honestly face the fiscal consequences.

11. States should not attempt to enact price controls on prescription drugs.

Nor should they enact measures that require pharmaceutical companies to give a supplemental rebate on their products in return for the state allowing doctors to prescribe those companies' products for Medicaid patients. Such schemes, which essentially amount to blackmail, are ethically unacceptable.

On a practical level, they are likely to result in serious damage to the capacity of the pharmaceutical industry to develop and market valuable new drugs at a time when the use of drugs to preclude far more costly hospitalization has improved the quality of life for millions of consumers, and saved them (and state governments) untold billions of dollars.

States that restrict access to drugs for Medicaid patients to older, less expensive, or generic drugs should require proof in every case that the savings would not be outweighed by the higher costs of recurring treatment and hospitalization that newer and more expensive drugs may be able to avoid.

12. States and local governments should support community health centers.

Such clinics, with local community support and partially staffed by volunteer medical professionals, can play an important role in preventive care and treatment of non-acute medical problems for people not enrolled in Medicaid or in transition between jobs. Helping them meet overhead expenses is a valid use for taxpayer dollars, especially where the availability of low-cost clinic treatment reduces patient visits to high-cost hospital emergency rooms.

13. States should repeal Certificate of Need (CON) programs that regulate the expansion of medical facilities.

The CON process, enacted to prevent costly duplication of facilities, has rarely if ever achieved that result. Maintaining a competitive market requires easy access by competitors who believe they can offer health care more efficiently and satisfactorily than existing providers. The CON process has more often been used as a weapon by politically powerful providers to deny entry to those competitors and thus preserve a service monopoly.

14. States should allow greater flexibility in practice boundaries among health care professionals.

As is relatively common in medically underserved rural areas, trained and experienced nurses, physician assistants, and nurse practitioners should be allowed to administer treatments where patient risks and opportunity costs are low and the time and money costs of engaging a physician are high. Such flexibility does involve higher patient risk, but it may well not be so high as the risk incurred by delaying treatment until examination by a physician is possible. The use of telemedicine makes such flexibility much more feasible.

15. States should encourage individuals to purchase long-term care insurance.

Consumers who purchase LTC policies receive a predetermined level of benefits for long-term care services through a private insurer. If the benefits under the private plan are exhausted and the individual still requires services, states should make Medicaid assistance available, but allow the patient to exclude the value of the benefits purchased under the policy from Medicaid's required spend-down of the patient's assets.

This relatively new type of insurance is most cost-effective when contracted for early in adult life. As such, its beneficial effects are far in the future. Nonetheless, as a way of easing Medicaid problems in the future, states should offer favorable tax treatment for LTC premiums, while avoiding rigid requirements on policy design.

States should also inform people about viatical life insurance policies, which advance payments to living insureds for their imminent end-of-life medical expenses.

For more information…

WWW on the Ethan Allen Institute, visit its Web site at **http://www.ethanallen.org** or contact John McClaughry by email at **eai@ethanallen.org**. For more information on State Policy Network, visit its Web site at **http://www.spn.org**.

16. States should consider pooling state and local government employees into a large health care plan.

Like the Federal Employees Health Benefits Program (FEHBP), such a plan should offer numerous coverage choices. The employing governments would make defined contributions on behalf of their employees, and the employees would choose the policies that best meet their needs, adding their own funds as required. Such a program ought to be designed to promote an MSA-high deductible option, and operate through debit card technology.

17. States should seek to recover through their income tax systems the costs of uncompensated care provided to persons who choose not to buy health insurance.

Providers would report the costs of uncompensated care to the state tax department on a 1099-type form in the patient's name. For example, the patient could be required to add the lesser of one-tenth of the total uncompensated cost or $10,000, to his or her reported gross income each year. The balance would be carried forward for up to 10 years.

Whatever is collected from taxpayers would be remitted to the account of the provider. For persons with low or zero income tax liability, little or no funds would be recovered. For persons in higher tax brackets who ought to be able to pay insurance premiums but choose not to, the recovery requirement would discourage going without health insurance in the expectation that providers would write off the cost of their services as charity care.

While the receipts from this program would fall far short of recovering the total uncompensated costs, the program would encourage personal responsibility and the purchase of insurance coverage.

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Are We Eating Ourselves to Death?

MICHAEL ARNOLD GLUECK, M.D AND ROBERT J. CIHAK, M.D.

Is there or is there not an epidemic of obesity? Should you worry about that growing cummerbund around your waist? Of course not. We all perished 10 years ago in the global famine, so confidently predicted by the environmental apocalyptics of the 1970s. Or had you forgotten?

But maybe we should worry ... because there's another apocalypse coming. This time, if you believe the Guardians of Girth and Dictators of Diet, America is about to become the first nation in history to eat itself to death.

Clearly, Americans weigh more than they used to. So does much of the rest of the human race. (Spend some time looking at armor or clothing in a museum, or travel to Japan if you doubt this.) But there is an epidemic of muddled diagnosis and wrong-headed thinking on this heavy subject.

Two Facts, for Starters

First, "overweight" is an arbitrary and to some extent culturally defined construct, a set of height/weight/body type/body fat percentage relationships you read off a chart. Any individual's comfortable and healthful, let alone "ideal," weight might vary significantly. Metabolism matters. So does occupation, lifestyle, and myriad other factors.

Second, overweight (as opposed to genuine obesity) is in most instances the result of the human body's natural ability to store extra calories as fat—a survival-enhancing mechanism from those eons when you never knew when the next woolly mammoth barbecue might be. "Calorie" is actually a measure of heat or energy. The image of the body "burning up" calories is pretty close to the physiologic truth.

For every extra 3,300 calories accumulated and stored as fat in the body, you gain one pound of fat weight, plus extra fluids. Further, whatever the nutrient value of specific foods may be, all calories are created equal. As Michael Fumento, author of *The Fat of the Land*, writes: "Maintaining a healthful body weight is no more complex or magical than simply balancing calories burned vs. calories consumed, regardless of the source."

They're Wrong

If overweight is an epidemic, the national health statistics should show it. But statistically—and despite all the other fashionable fears—we're actually getting healthier and living longer, better lives. So, what's going on?

At one level, it's snobbery: the elitist conviction that Americans can't be trusted to take care of themselves, and that the "Holier/Healthier than Thou" crowd must therefore lobby and legislate and sue and try to force people to live according to their standards. Social engineering and coercion flaunt "scientific" evidence that doesn't stand up, often for the simple reason that it doesn't exist to begin with.

As Steve Milloy of junkscience.com writes, "the simplistic notion that dietary fat is bad was a political and business judgment, not a scientific one."

It seems to have started back in 1977, when a Senate committee led by George McGovern issued a report advising Americans to consume less fat to avoid "killer diseases," then supposedly sweeping the country.

"If overweight is an epidemic, the national health statistics should show it. But statistically ... we're actually getting healthier and living longer, better lives."

The politically dutiful National Institutes of Health joined the anti-fat bandwagon, a move that spawned the low-fat food industry—a boon to consumer choice, but not necessarily one with a beneficial health impact.

As Fumento notes: "Since 1977-78, fat as a percentage of our diets has dropped by over 17 percent, even as obesity has increased by over 25 percent. The fewer calories we've taken in from fat, the fatter we've become."

But the low-fat bandwagon was a boon to activists seeking funding and power, especially the Food and Drug Administration, the National Academy of Sciences' Institute of Medicine, the National Institutes of Health, and the Center for Science in the Public Interest.

If you were lucky enough to get some exercise equipment or a health-club membership last Christmas or Hanukah, do use it. In moderation, of course. Overdoing efforts to get the calories off can be more dangerous than putting them on.

Michael Arnold Glueck, M.D. is a multiple award-winning writer who comments on medical-legal issues. Robert J. Cihak, M.D. is a former president of the Association of American Physicians and Surgeons. Both doctors are Harvard-trained diagnostic radiologists.

For more information…

WWW Michael Fumento's *The Fat of the Land: The Obesity Epidemic and How Overweight Americans Can Help Themselves*, was published in 1997 by the Viking Press. Although it is out of print, new and used editions are available through Amazon.com. Point your Web browser to **http://www.amazon.com/exec/obidos/ASIN/0670870595/theheartlandinst.**

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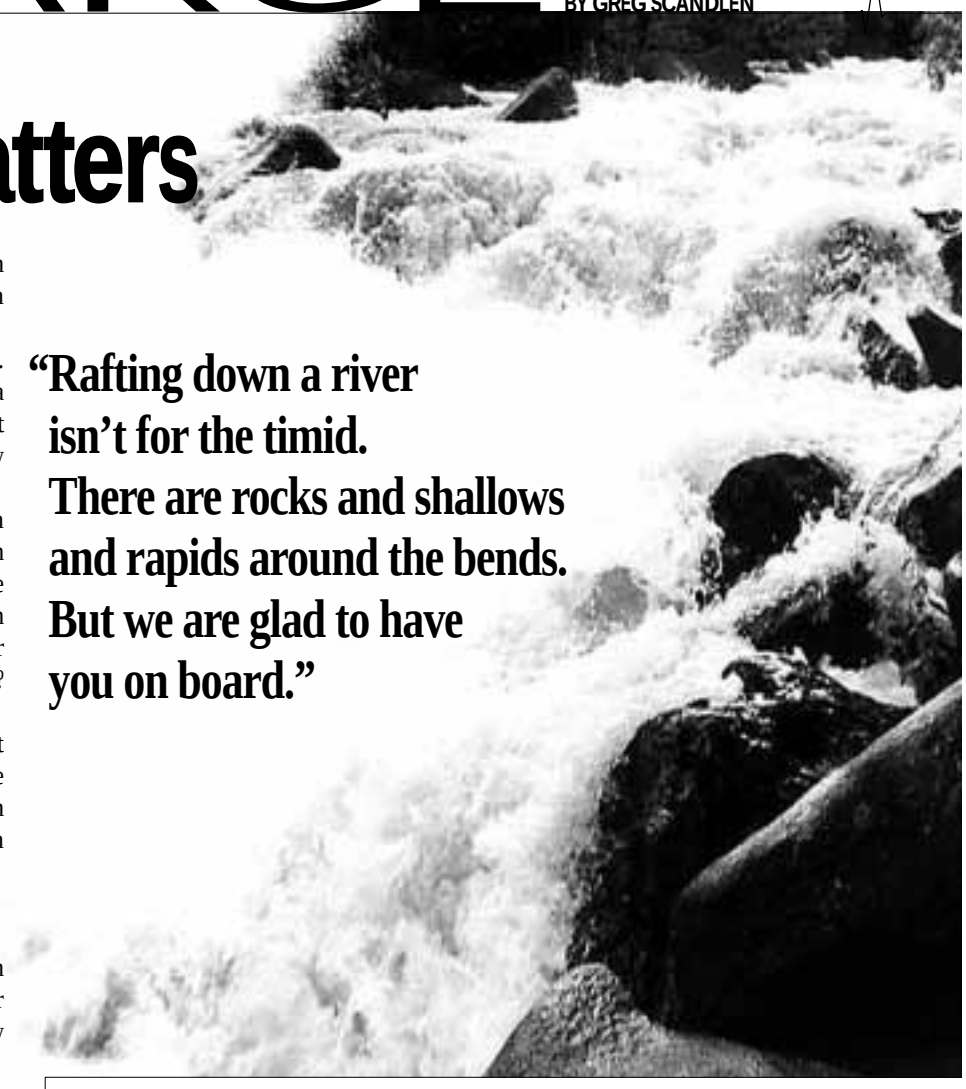
BY GREG SCANDLEN

Consumer Choice Matters


"Rafting down a river
isn't for the timid.
There are rocks and shallows
and rapids around the bends.
But we are glad to have
you on board."

With this issue of *Health Care News*, I'm launching a new focus for this column on consumer choice matters. As the new director of the Galen Institute's Center for Consumer Driven Health Care, I hope to help fill the knowledge gap on new developments around the country as the movement for increased consumerism in health care finds increased acceptance.

There is so much going on in the area of consumer-driven health care that writing about it in a linear fashion is almost impossible. It's like trying to describe a river. Do you start with the rapids, the eddies, the banks, or the islands? What is most important: how long, how wide, or how deep it is? The muddy water that has just passed by, or the fresh water yet to come?

Many Players

The movement towards consumer-driven health care is every bit as complex and fast-moving as a river.

My colleague Joe Moser and I are trying to develop a list of the companies involved in this movement, but how should we classify them? There are patient education programs, insurance products, third-party administrators, software companies, debit card companies, banks and mutual funds, physician networks, quality assessment efforts, e-management firms, brokers, advisors, consultants, and venture capital companies. Some firms have already come and gone, others are just starting up, and others have completely revamped their original concept.

Of course there are other important players, too: employers, regulators, legislators, physicians, hospitals, nurses, economists, and most important of all, individual consumers of health care services.

The river of consumer-driven health care is sweeping up all of these players. After 50 years of ever-greater reliance on third parties to make decisions for individual consumers, the tide has changed. Virtually no one thinks the United States, or any other developed country, can continue to treat individuals as passive recipients of services granted by paternalistic bureaucracies.

The American people are increasingly well-educated and self-confident in making their own decisions about what is best for their families. Company health plans will soon become as anachronistic as company cars, company housing, or company towns. We no longer look to our employers to provide us with a home or a car. We expect to be paid good wages for good work, and we will decide how best to spend our own hard-earned money.

Doing Our Own Thing

Recently many of us have discovered that we can't always trust our employers for guidance on how to invest our 401(k) funds. What is best for management isn't always best for the rest of us.

The same is true for health care. The industrial age is behind us. There is no guaranteed employment. We change jobs every few years. In the information age we need to make our own health care decisions. We need to control our own health care resources. We need to own our own insurance policies.

It isn't that employers have done a poor job. They didn't ask for the responsibility of running a health plan. It was thrust on them the same way it was thrust on us. They've done the best job they could for a very long time.

But imagine if you were told that from now on you would have to manage your neighbors' health care. You would have to make all their health care decisions. You would have to decide how much money to spend. You would decide what doctor they could see. How would they feel about you? How would you feel about them?

It would be an impossible situation—one that would create tension and hostility where there was none and shouldn't be any. And the situation would be no better if the responsibility were given to a government employee instead.

Moving the Elephant

But moving a $1.3 trillion industry elephant from reliance on third-party paternalism to consumer empowerment is no easy job. It will take many years to get there.

We have already taken the first few steps with the enactment of medical savings accounts, the establishment of health reimbursement arrangements, the creation of Internet enrollment and patient education, and the beginnings of defined contribution approaches to health plan purchasing.

Not everything we try will work. There will be errors and missteps, corrections and revisions. There will also be hopeful signs and success stories. Galen's Center for Consumer Driven Health Care will monitor all of this, and report on it in this column as well as in a regular email newsletter called Consumer Choice Matters.

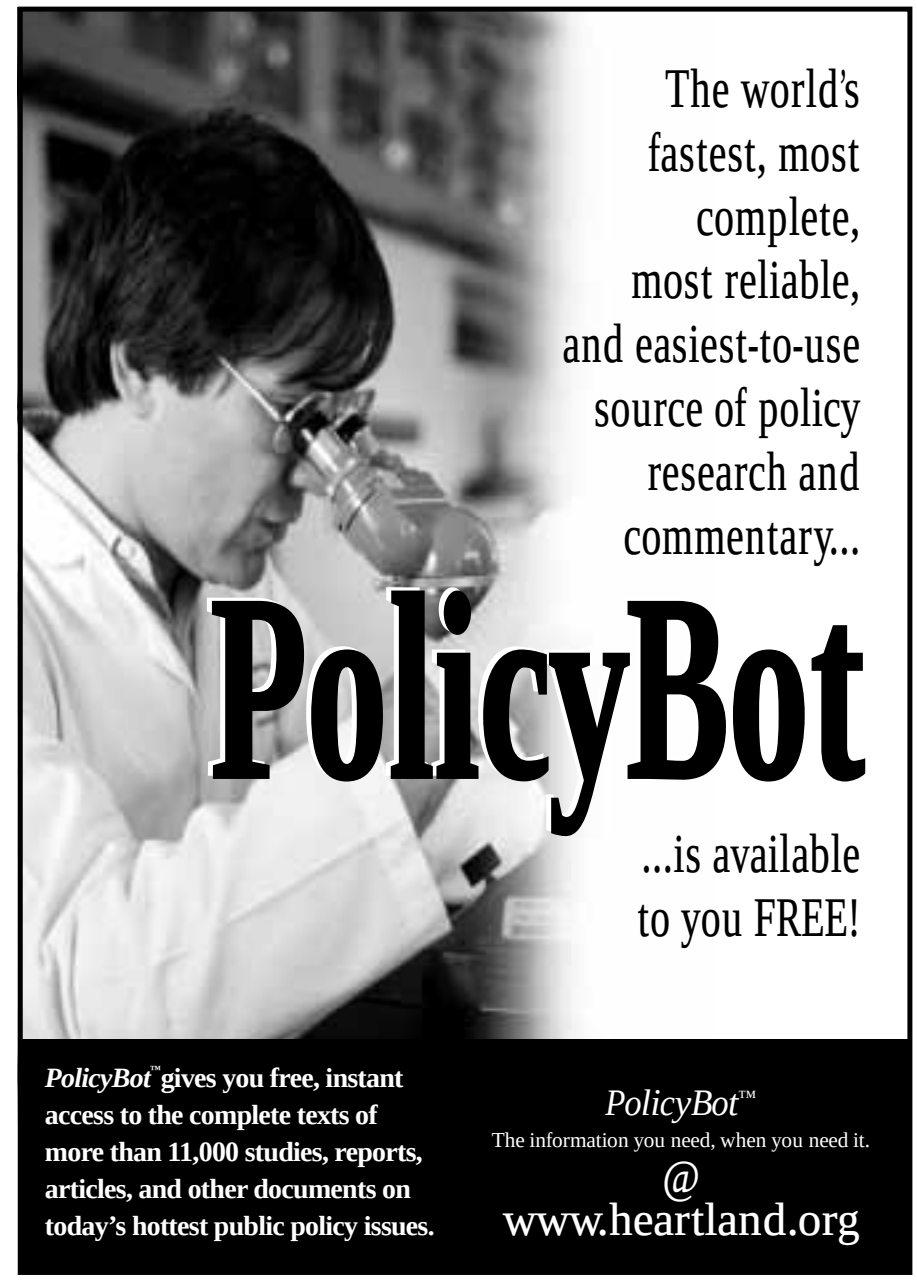
We will try to provide an honest evaluation of the good and the bad, not just be cheerleaders for every screwball idea that comes along. We will review news reports, research papers, press releases, and testimony and provide you with source material, including hard links whenever possible.

The Center will also work on educating decision-makers—employers, politicians, physicians, insurers, and consumers—on what works and what doesn't. We expect to be giving speeches and appearing in the media all over the country, publishing research reports, giving testimony, and writing commentary.

We don't have a monopoly on good ideas, and we hope you will become an active participant in the process. We hope to make our work as interactive as possible, so we can all learn from each other as we go along.

Rafting down a river isn't for the timid. There are rocks and shallows and rapids around the bends. But we are glad to have you on board.

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *His email address is* galen@galen.org.



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State UPDATE

A MONTHLY REVIEW OF STATE HEALTH CARE ACTIVITY

MANAGING EDITOR'S NOTE:

Health Care News is expanding its coverage of state-based health care news. If you have news to share regarding legislative, political, legal, and business developments in your state's health care arena, please contact me at **meier@heartland.org**.

Spotlight on...

Missouri

Governor Bob Holden (D) has put forward a measure that would require Medicaid beneficiaries to pay co-payments of 50 cents to $3 for doctor visits and other services as part of an effort to cut $280 million from the state budget.

ARIZONA

Drug Price Controls

Governor Janet Napolitano (D) launched through an executive order a program that would entitle about 600,000 seniors and disabled Arizona residents to use a discount card to buy prescription drugs at cheaper prices. Residents 65 years or older would pay a $25 annual fee to participate in the program.

Before Napolitano's plan can go into effect, a network of pharmacies choosing to participate will have to agree to drug price controls established by the state. Napolitano, who bypassed the Republican-controlled legislature with her order, thinks the program could be up and running by the end of April.

Last year, a similar idea died in the state legislature as lawmakers balked at the use of price controls—and the estimated $1 million start-up cost. Napolitano projected her program would cost the state nothing, saying the $25 enrollment fee would cover the costs.

Arizona Republic
January 8, 2003

COLORADO

Medicaid Failure

Colorado state is dismantling its Medicaid HMO program, started in 1995 as part of a federal pilot program to reduce health costs and improve care, the *Denver Post* reports.

Karen Reinertson, executive director of Colorado's Department of Health Care Policy and Financing, called the program a "failed experiment," noting the HMO plans are not saving the state enough money. She noted the Medicaid HMO program is spending more on administration costs than on medical care. The state Medicaid program costs about $2 billion annually: one-third of the state budget.

Lexis/Nexis news search 01/12/03
Denver Post

KENTUCKY

More Cuts Needed

Governor Paul Patton (D) announced a Medicaid reform proposal that would employ several methods in an effort to curtail Medicare spending, including ending some coverage for nursing home and at-home care, imposing fees for dental and other health services, and trimming reimbursements for outpatient hospital care.

The proposal is designed to cut about $250 million in Medicaid costs. Even with those cuts, the program still would report a $200 million deficit.

Owensboro Messenger-Inquirer
Associated Press, 01/17/2002

MARYLAND

Exploding Costs

Health care spending increased by 11.8 percent in 2001—the biggest jump since the state began tracking health spending in 1995, according to a report issued by the Maryland Health Care Commission. "All service sectors are accelerating rapidly," said Ben Steffen, the commission's deputy director.

Patients, insurers, employers, and government programs in the state spent $21 billion on health care in 2001, up from $18.8 billion in 2000. The report includes spending on inpatient care, outpatient care, physician fees, prescriptions, and nursing home care. Steffen noted some health-related spending, such as workers' compensation claims and auto insurance payments, was not included in the report.

Hospital outpatient care, including ER visits, saw the most rapid increase, at 18 percent. Out-of-pocket expenses for patients grew 13 percent, while spending by insurers grew 12 percent. The difference, according to Steffen, was explained by increasing deductibles and co-payments.

Until 2000, health care spending in Maryland was increasing at a rate lower than the national average. Steffen thinks the higher spending since then is due to falling HMO enrollment, which meant fewer patients were subject to the tight cost controls imposed by HMOs. Of Maryland residents with health insurance, 34.9 percent were enrolled in HMOs in 2001, compared with 39.5 percent in 2000, the report said.

Jon Gabel, vice president of health systems studies at the Health Research and Educational Trust, disagreed with Steffens' assessment. Gabel said increased health spending in the state, and the nation as well, stems from a loosening of controls on managed care plans since the 1990s.

Patient demand for less micro-management of their health care has caused managed care plans to reduce or drop some restrictions on care, such as pre-authorizations and gatekeeper doctors who controlled access to specialists.

Maryland Health Commission Report, 01/16/03
Baltimore Sun, 01/17/03

MASSACHUSETTS

Pass and Repeal

State Senator Richard Moore (D) has introduced legislation to repeal the state's $2 co-pay for Medicaid prescriptions. Effective in January, the state increased the co-pay from 50 cents to $2 per prescription. Pharmacists say the additional payment is creating a barrier to treatment for beneficiaries with mental illnesses, some of whom already have difficulty adhering to medication regimens.

Providers are saying people with mental illnesses, who typically are "poorly organized and living on extremely restrictive incomes," might not be aware of the higher co-pay. When they pick up their prescriptions and then learn of the requirement, that might be enough to discourage them from paying for and taking the prescription.

Advocates for repeal claim mentally ill patients should have been included in the list of "vulnerable" populations exempt from the co-payment. The list currently covers children under age 19, pregnant women, mothers with newborns, nursing home residents, those living in intermediate care facilities, people with mental retardation, and those suffering from chronic diseases.

The Boston Globe, 01/20/03

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MICHIGAN

Who's on First?

A new study from the Kaiser Commission on the Uninsured examines the state's Pharmaceutical Product List program. The current formulary forces drug companies to provide discounts in order to have their medications placed on the state's approved prescription drug list for Medicaid and other public health insurance programs.

The Kaiser report noted implementation of the program did not go smoothly, in part due to the state's desire to institute it rapidly. The implementation process excluded key stakeholders, and ineffective communication led to delays in beneficiary access to medication.

The report also finds the formulary too restrictive for a relatively expensive class of drugs used for treating mental health conditions, cardiac problems, and diabetes.

The Michigan Department of Community Health, which runs the formulary program, did not participate in the research leading to the report. Geralyn Lasher, a department spokesperson, told the Associated Press, "I'm not sitting here saying that everything went off without a hitch. When you make such a major change, of course there are going to be a lot of questions."

Associated Press reports
January 15, 2003
Michigan Department of Community Health

MISSOURI

Increase the Co-pay

Governor Bob Holden (D) has put forward a measure that would require Medicaid beneficiaries to pay co-payments of 50 cents to $3 for doctor visits and other services as part of an effort to cut $280 million from the state budget, the *Kansas City Star* reported. Most of the program's 900,000 beneficiaries currently do not make any co-pays for physician visits.

Officials in the Department of Social Services predict the proposed co-pays would save the state $65.8 million. Holden is trying to cut a total of $150 million from the Medicaid program.

Columbia Tribune
Kansas City Star, 01/16/03

NEVADA

What Are Neighbors For?

After nine states and the District of Columbia announced a not-for-profit multi-state partnership to manage prescription drug benefits under Medicaid, Nevada legislators say they might partner with an undisclosed neighbor state in a similar effort. Costlier drugs and growing Medicaid enrollment contributed to $79 million in drug costs for the program last year, up from $59 million in 2001.

Las Vegas Sun
State Department of Health, 01/16/03

NORTH CAROLINA

State of the Obvious

The state Department of Health and Human Services needs to reform "long-standing problems" in the state's Medicaid program, says Governor Mike Easley (D). Accounting problems, which health officials first learned about last summer, led to overpayments to hospitals since 1997 that could total a "few million" or a "few hundred million," according to news reports from the *Raleigh News & Observer*.

Hospital officials reportedly said accounting errors likely led to "minimal" overpayments, although a health department document says the total could be as high as $625 million, according to the *News & Observer*. Health department officials said they are extending a $64,000 contract with consulting firm Tucker Alan to probe possible overpayments.

Lexis/Nexis news search, 1/26/03

PENNSYLVANIA

Fluff Stuff

Keystone State Governor Ed Rendell (D) has announced a new state agency to address the medical malpractice insurance crisis and coordinate efforts to reduce health care costs. The new Office of Health Care Reform will have authority over the state Departments of Aging, Health, Insurance and Public Welfare, as well as other departments that regulate or deliver health care services.

The agency will have a limited, as yet undetermined, budget and a small staff, led by Rosemarie Greco, former president and CEO of CoreStates Bank. The agency will work to reduce costs in the state's $7 billion health care system and will partner with a task force established by Rendell to address high malpractice insurance rates in the state.

Although the new agency will not have regulatory authority, Greco will report directly to Rendell and will help implement agency recommendations the governor approves.

University of Pennsylvania health economist Mark Pauly said the agency might improve the "quality and satisfaction of care of public clients but will not likely reduce health care costs in the state."

Associated Press wire services
Google Advanced News Search, 01/26/03

TENNESSEE

Can't Get a Break

Because the state overestimated cost savings as a result of reforms to TennCare, the state's Medicaid managed care program, the program has a budget shortfall of $258 million.

After receiving a federal waiver last year to restructure TennCare benefits and eligibility, the state began a process to reverify eligibility for current beneficiaries. The state planned to save about $150 per person for beneficiaries cut from the program, but those savings amounted to only about $100 per person.

Program Director Manny Martins told lawmakers if a federal appeals court upholds a lower court ruling ordering Tennessee to reinstate benefits to those who lost them, the program's budget deficit could grow by between $260 million and $300 million.

Manny Martins testimony to the state legislature, 01/15/03
Memphis Commercial Appeal, 01/16/03

VERMONT

Finally a Good Idea

Incoming Republican Governor Jim Douglas announced in January that "Vermont has expanded its Medicaid benefit package to include those who do not qualify for traditional Medicaid." The reform package concentrates on making health insurance more affordable by using a tax-deductible medical savings account (MSA) program tiered to income.

The target group for the pilot project will be uninsured or underinsured children from families with annual incomes between 225 percent and 300 percent of the federal poverty level. Enrollment in the program will be voluntary. Enrollees will receive the same medical benefits as Medicaid-covered children who are not enrolled in the MSA.

Legislation authored in 2002 by Representative Tom Koch (R-Barre) directed the state's agency for Medicaid to devise a voucher to help the Medicaid population buy health insurance.

Families will fund the MSA with their current program fee payments, established at $600 per year for uninsured children, and $288 per year per family for underinsured children. Preliminary estimates are that up to 1,000 families may volunteer to enroll in the MSA program. The proposal cannot go into effect until it receives a waiver from the Centers for Medicare and Medicaid.

John McClaughry, Ethan Allen Institute, 01/26/03

WEST VIRGINIA

Leaving Home Without it

According to a survey of West Virginia physicians commissioned by the U.S. Chamber of Commerce, inflationary medical malpractice insurance rates have forced many physicians to leave the state, hurting the quality of patient care.

The survey of 289 West Virginia physicians, conducted by Harris Interactive, found a "substantial majority believe that the state's malpractice liability system is undermining the practice of medicine and the delivery of health care."

In addition, about 90 percent of physicians surveyed said they "do not feel they can trust the current justice system to achieve reasonable outcomes," and about two-thirds said they have considered moving to a different state as a result of high malpractice insurance rates.

About 90 percent of physicians surveyed said West Virginia has a physician shortage, and almost all attributed the problem in part to malpractice liability.

Kate Sullivan, director of health care policy for the U.S. Chamber of Commerce, called the poll "a siren call to West Virginia that their state's litigation system is in critical condition." Sullivan added, "Lawmakers must make meaningful changes to heal the civil justice system before patients suffer."

U.S. Chamber of Commerce press release
Harris Interactive Surveys, 01/13/03

Conrad F. Meier is managing editor of Health Care News.

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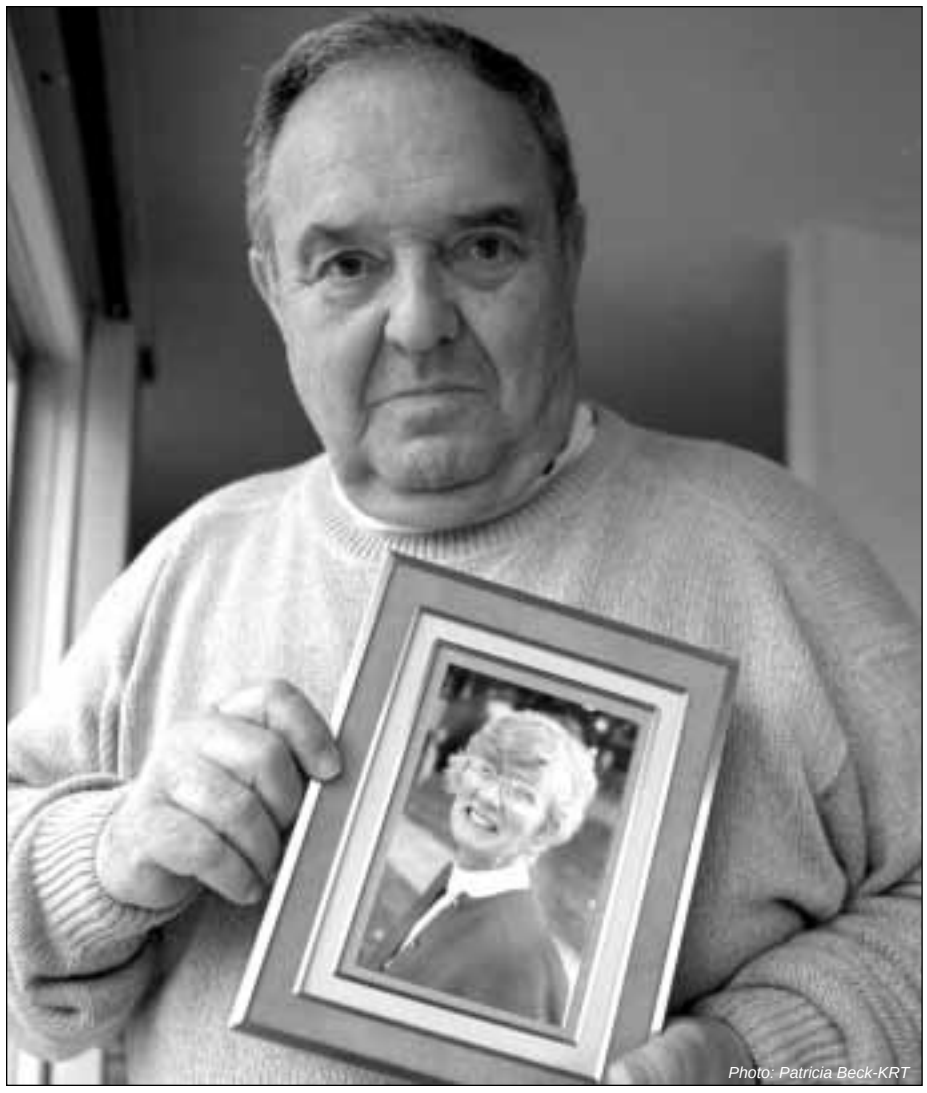

John Malejan's long-term care policy paid for the nursing his late wife, Louis, needed after she developed Alzheimer's.

LONG-TERM continued from page 1

qualifies the top tier of seniors.

In 30 "medically needy" states, people qualify if they cannot afford private nursing home care, which averages nearly $5,000 per month. In the remaining "income cap" states, most people with monthly income in excess of the ostensible $1,635 limit can set up Miller income trusts and qualify immediately. As of 2003, married couples are allowed to keep up to an additional $2,267 per month in income for the healthy spouse at home while the ill spouse receives nursing home care paid for by Medicaid.

"No wonder nursing homes are struggling financially. Their dependency on stingy government reimbursements is increasing while their more profitable private payers are disappearing."

Nor do assets interfere with Medicaid nursing home eligibility for most people. While Medicaid recipients are allowed only $2,000 in non-exempt assets, they can also retain a home and all contiguous property of unlimited value, a business including the capital and cash flow of unlimited value, one automobile of unlimited value (if used for the recipient's benefit), a burial trust fund of unlimited value, practically unlimited home furnishings, and many other exempt assets.

For people with really large financial holdings, Medicaid planning attorneys can quickly shelter or divest their wealth to achieve artificial impoverishment by means of sophisticated legal techniques. These include special trusts, annuities, self-canceling installment notes, life care contracts, and many others. Married couples can shelter half their joint assets up to $90,660 in addition to all the other exemptions.

For more information…

WWW see "LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle," published by the Center for Long-Term Care Financing in September 1998. The 37-page report is available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for document #**11573**.

The average American senior qualifies easily for Medicaid nursing home benefits without fancy Medicaid planning, and virtually anyone else can qualify by hiring a Medicaid planner. The legal fee to impoverish even the well-to-do so they can receive Medicaid nursing home benefits is roughly equal on average to the cost of one month in a nursing home as a private payer.

The truth is that no one has to be poor to receive nursing home care paid for by Medicaid. All anyone needs is a cash flow problem. Consequently, many people who could afford home care or assisted living by liquidating real estate or other exempt assets end up in nursing homes on Medicaid because that is the cheapest alternative available to them and their families.

Devastating Consequences

The consequences to America's long-term care service delivery and financing system have been devastating. The percentage of nursing home costs paid by government (mostly Medicaid and Medicare) has been going up for the past 13 years (from 49.6 percent in 1988 to 61.5 percent in 2001, up 11.9 percent), while out-of-pocket costs have been declining (from 38.5 percent in 1988 to 27.2 percent in 2001, down 11.3 percent).

Thus, the consumer's liability for nursing home costs has gone down precipitously, while the government's liability has increased dramatically. No wonder nursing homes are struggling financially. Their dependency on stingy government reimbursements is increasing while their more profitable private payers are disappearing. And no wonder people are not buying LTC insurance as eagerly as insurers would like them to. Only 7 percent of seniors and hardly any of the baby boomers have insured privately for long-term care.

Unfortunately, these problems are even worse than the preceding data suggest. Over half of the so-called "out-of-pocket" costs reported by the Centers for Medicare and Medicaid Services are really just contributions toward their cost of care by people already covered by Medicaid!

These are not out-of-pocket costs in terms of asset spend-down, but rather only income, most of which comes from Social Security benefits, another government program. Thus, although Medicaid pays less than half the cost of nursing home care (47.5 percent of the dollars in 2001), it covers 70 percent of all nursing home residents. Because people in nursing homes on Medicaid tend to be long-stayers, Medicaid pays something toward nearly 80 percent of all patient days.

No wonder the public is not as worried about nursing home costs as LTC insurers think they should be. No wonder nursing homes are facing bankruptcy all around the United States, when so much of their revenue comes from Medicaid, often at reimbursement rates less than the actual cost of care.

Bottom Line

Well-intentioned but perversely counterproductive public policy has anesthetized most Americans to the risk and cost of long-term care. For nearly 40 years, they have been able to ignore the risk, avoid the premiums for private insurance, and expect Medicaid and Medicare to pay for their long-term care if and when it's needed.

Unfortunately, that old system is falling apart as access to and quality of government-financed long-term care have collapsed over the past decade. Already now, and far more so in the future, access to quality long-term care at the most appropriate and desirable levels (home care or assisted living) will require an ability to pay privately.

We desperately need a change in public policy incentives to encourage Americans to take the risk of long-term care seriously, to plan early, and to save, invest, or insure so they can pay privately when they need long-term care.

Stephen A. Moses is president of the Center for Long-Term Care Financing in Seattle, Washington. He can be reached by email at smoses@centerltc.org, or by phone at 206/283-7036.

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The Galen REPORT

GALEN INSTITUTE

A MONTHLY REVIEW OF HEALTH POLICY MATTERS

Nobel laureate Milton Friedman has long been interested in health policy and the importance of reforms that will promote greater individual freedom.

I had written asking to meet him, so as to get his guidance on carrying free-market ideas forward in what should be the best climate for progress in well over a decade.

He reinforced his concern, detailed in an article he wrote in the Winter 2001 issue of *The Public Interest*, about government expenditures accounting for 45 percent of total health spending in the United States. "We are headed toward completely socialized medicine and are already halfway there, if in addition to direct costs, we include indirect tax subsidies."

"We are headed toward completely socialized medicine and are already halfway there, if in addition to direct costs, we include indirect tax subsidies."

MILTON FRIEDMAN

He insists it is important to stay focused on the big picture but admits his policy prescriptions may not be politically feasible. He advocates repealing the tax exemption for employer-provided medical care; terminating the existing Medicare and Medicaid programs; deregulating most insurance; and restricting the role of government, preferably state and local rather than federal, to financing care for the hard cases.

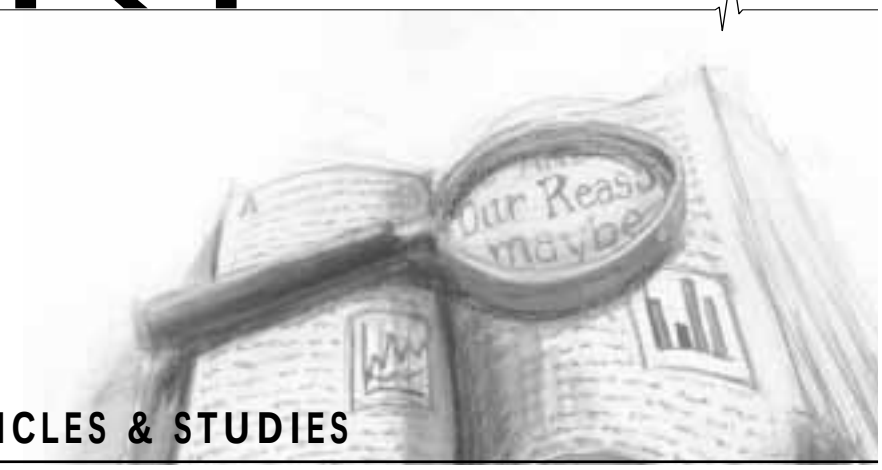
He believes realistic first steps should focus on liberalizing the rules governing medical savings accounts, and allowing Medicare beneficiaries to have access to the funds allocated on their behalf, first to protect against catastrophic medical expenses, then to have freedom in spending for routine care.

A strong advocate of MSAs, Friedman was very interested to learn about the new Health Reimbursement Arrangements (HRAs) authorized by the IRS last summer to essentially give medium-sized and large companies the opportunity to offer MSA-like products to their employees. We discussed the need for either legislation or a new ruling that will allow employee ownership of the money they save in their HRA accounts.

Those of us who slog in the trenches of public policy details every day do well to be reminded of the goal: Individual control over health spending decisions in a free and competitive marketplace that responds to empowered consumers.

— Grace-Marie Turner

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of *Health Care News*.



RECENT NEWS ARTICLES & STUDIES

Bailing out the States

Editorial Board
Wall Street Journal, 01/08/03

The best way to help states out of their current fiscal crises is to reform the mandates Washington imposes on governors, especially through Medicaid, says the *Wall Street Journal*. Federal aid, as suggested by Democrats in Congress, would be "a perverse reward for the wildly irresponsible spending of many states during the 1990s boom, and a punishment for the taxpayers of those states—like Colorado—that lived within their means."

The best solution is a simple block grant states can use as they see fit. States should also try to reform Medicaid themselves by applying for HIFA waivers from the Department of Health and Human Services. "The solution lies in scrapping its ineffective price controls and bureaucracy in favor of a market-driven system," the *Journal* says. "Washington can help states make the shift, through legislation or regulatory waivers. The last thing it should help them do now is bail out a broken system."

Full text (requires subscription): online.wsj.com/article/0,,SB104198615685522054 4-email,00.html

The Future of Medicaid: Consumer-directed Care

Jim Frogue
The Heritage Foundation, 1/10/03

"Congress and state officials should embark on an ambitious program of comprehensive Medicaid reform," says Jim Frogue of the American Legislative Exchange Council. He suggests a good model is the Cash and Counseling program that allows certain Medicaid beneficiaries to purchase their own services, with the help of a consultant, using a defined contribution from the state's Medicaid program. The beneficiary, not government bureaucrats or politicians, decides where, when, and by whom his or her care will be delivered.

Cash and Counseling programs in Arkansas, New Jersey, and Florida have experienced nearly a 100 percent satisfaction rate because consumers are making their own health care decisions, Frogue writes. "Instead of perpetuating the same old policy discussions, the new Medicaid debate must begin to focus on how the current system can be restructured to accommodate the beneficiaries and the doctors, hospitals, and other health care professionals who serve them in the most effective manner possible."

Full text: http://www.heritage.org/Research/HealthCare/ BG1618.cfm

Single Payer Singularly Unsuccessful

Linda Gorman
The Independence Institute, 01/13/03

A single-payer system is not the answer to Colorado's health care problems, says Linda Gorman, a senior fellow at the Boulder-based Independence Institute. "The largest single-payer systems in the United States, Medicare and Medicaid, have sabotaged private health care by systematically over promising, over regulating, and underpaying," says Gorman.

A better solution is market-based reform that reduces cost. According to the RAND health insurance experiment, consumers who used their own money to buy health care reduced spending by 30 percent without any detrimental effects on their health. A medical savings account plan (MSA) in Denver could save a couple with two children and average medical expenses about $500,000 over 40 years.

Gorman concludes, "Fifty years of experience has shown that single-payer systems produce lousy health care at exorbitant cost. Isn't it high time to try something else?"

Full text: http://www.i2i.org/Publications/Op-Eds/HealthCare/medicalhell.03Jan12.htm

Americans Need a Market for Medical Progress

Robert L. Pollock
Wall Street Journal, 1/22/03

Spending more on health care may not be a bad thing, says Rob Pollack of the *Wall Street Journal*. "If you attribute even minimal dollar value to an added year of healthy life, and a small portion of increasing life span to better medical care, it's hard to escape the conclusion that all that money is more than justified by the results," says Pollock. "If you'd like the survival rates for cancer and other diseases to keep rising, the inescapable conclusion is that we don't have a cost crisis. If there's a crisis, it's a crisis in the way health care is financed."

Pollock proposes reforming health care financing by explaining to consumers the true cost of health care, "reacquainting them with the real meaning of insurance," and replacing Medicare with a system in which the government would buy beneficiaries private insurance "rather than handling all the bills itself."

Full text (requires subscription): http://www.online.wsj.com/article_print/0,,SB104319850529775 9864,00.html

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My TURN

BY CONRAD MEIER - MANAGING EDITOR

Need a Doctor? Call a Lawyer!

The barriers to affordable health care in the U.S. have long included outdated government-run programs like Medicare and Medicaid and an over-abundance of mandates and regulations imposed on the health care industry. Now, we must include the titanic costs of malpractice insurance.

Litigation is increasing the price of malpractice insurance for physicians, which in turn has increased the price of health insurance for consumers, reduced the supply of physicians, and made health care generally less affordable and less accessible.

Attack on Care Providers

Extreme financial judgments against health care providers work at cross-purposes with efforts to extend affordable health insurance to the uninsured population.

Mega-bucks settlements have made malpractice insurance unaffordable and unavailable to many health care providers. As a result, many doctors are being compelled to retire at the peak of their careers, limit their medical practices to all but the most routine health care procedures, shift their energies into research rather than practice, or move to a state with reasonable malpractice laws.

Nursing home care has been especially hard hit, in part because of the increase in the number of senior citizens served by those facilities. Both the number of lawsuits and the size of awards are trending up.

Between 1995 and 2001, according to a February 2002 study by Aon Risk Consultants Inc., the national average of insurance costs for nursing homes increased from $240 per occupied skilled nursing bed to $2,360. From 1990 to 2001, the average dollar size of claims tripled and the number of claims per bed increased from 3.6 to 11 per 1,000 beds.

Consumers Suffer

The lack of affordable insurance for *providers* makes it more difficult for *consumers* to get affordable, accessible health care—especially for high-risk medical specialties, such as obstetrics and neurosurgery, and in underserved rural communities.

With fewer doctors available, we are beginning to experience longer wait times for an appointment, queuing at hospitals, and a shortage of medical specialists trained to tackle the tough medical cases.

We are also experiencing the price inflation caused by "defensive medicine."

The actions taken by physician-defendants often years before a malpractice suit goes to trial are carefully scrutinized and often judged on the basis of medical standards that were not in place at the time the alleged malpractice took place.

Because they cannot be certain their usual procedures won't be judged by the litigation system as "lacking" some years into the future, physicians today are adjusting their treatment protocols to cover all the bases. The malpractice lottery thus inflates the cost of medical care by forcing doctors to overtreat and over-test their patients.

In a "Fear of Litigation" survey conducted in mid-April 2002 by Harris Interactive, doctors reported they perform tests and provide treatments they would not ordinarily perform, simply to protect themselves against a potential lawsuit. Seventy-six percent of respondents to the Harris survey felt their ability to provide quality care to patients has been compromised as a result.

This practice of defensive medicine, while useful in a courtroom, does little or nothing to enhance patient outcomes. Every test and treatment poses a risk to the patient. Those tests and treatments also cost money ... some health economists suggest the cost of defensive medicine now exceeds $100 billion a year.

No Simple Solution

On February 5, Rep. Jim Greenwood (R-Pennsylvania) reintroduced medical malpractice reform legislation in the House of Representatives. The Help Efficient, Accessible, Low-Cost, Timely Health Care Act (HEALTH Act, H.R 5) would, among other things, cap non-economic damages in medical malpractice cases at $250,000 and limit punitive damages to the greater of $250,000 or twice economic damages. The measure—virtually identical to a 2002 version that passed the House last September but died in the Senate—had attracted more than 65 cosponsors by February 10.

Opponents of the measure, including Republicans, many Democrats, trial attorneys, and some consumer groups, argue the caps would deny innocent victims or their survivors of compensation they deserve. Even as Senate leaders voiced support for the Act, they acknowledged passing legislation in the Senate would be difficult.

Senator Rick Santorum (R-Pennsylvania) says the new bill could serve as a starting point for debate but "has little chance of passing." "We're going to have to be a little more creative," said Santorum, noting the answer to rising malpractice premiums is not as simple as merely capping damage awards.

Significant reform must be a top priority for the 108th Congress. While there seems to be little consensus among major interest groups on the nature of the malpractice problem, its severity, its solutions, or the proper role of government in fixing the situation, one thing is certain: Consumers are getting short shrift.

Conrad F. Meier is managing editor of Health Care News.

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